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Global Mental Health, Traumatic Stress, and Displaced Families

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Traumatic stress induced by war, violence, disasters, and resulting displacement around the world is at an all-time high and predicted to increase as the political, environmental, and social fabrics of our global community are further strained (Benjet et al., 2016; Frantz, 2017). Referred to as *mass trauma*, these events affect entire parts of the world, and populations for that matter, simultaneously (Chang, 2009). They include natural (e.g., flooding, earthquake, and hurricane) and human-made disasters (e.g., organized violence, war, land degradation), in addition to infrastructure failures (e.g., bridge collapse, dam failure, and power outage). Additional stressors trickle down from large-scale traumatic events. Displacement induced by conflict has perhaps the most poignant system-wide impact as it ripples across not only the individual but also his or her family, their community, and culture as a whole (Wieling, 2018). Recent global displacement estimates topple 65 million people and are higher than those following World War II.

The overwhelming consequences of exposure to mass trauma and displacement demand multilevel systemic interventions that are culturally relevant while also meeting communities' mental health and relational needs. The majority of displaced persons live in low- to middle-income countries as asylum seekers or refugees. The top resettlement destinations for people displaced by violence, according to recent UNHCR (2015, 2016), are (a) the Middle East (39%), (b) North Africa (29%), (c) Asia (14%), (d) the Americas (12%), and (e) Europe (6%). Aside from Africa and Asia, particularly Western Asia, around half of all migrants are women and children (United Nations [UN], 2017b). Unaccompanied minors, undocumented migrants, and others without legal precedent are particularly vulnerable to the effects of mass trauma as they are forced to live in rural regions without access to adequate mental health services (Reed, Tyrer, & Fazel, 2016). Displaced minors face exhaustion, hunger, and possible exploitation and violence. Moreover, without a parental figure, they are at greater risk for developing psychological distress symptoms (Hodes, Jagdev, Chandra, & Cunnif, 2008). In general, no integrated systemic conceptualization addresses the scope and magnitude of mental health challenges of forcibly displaced populations. Many areas that host migrants have no infrastructure or clear means to provide mental health services.

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Research on traumatic stress primarily focuses on the individual. But recent evidence has documented the relational effects of traumatic stress on families, particularly the intergenerational transmission of psychopathology and maladaptive coping with adverse consequences for couple and family relationships (Catani, 2010; McIlwaine & O'Sullivan, 2015; Walsh, 2007; Weine, 2011; Weine et al., 2004; Wieling et al., 2015). Forced displacement also affects entire populations as evidenced by *internally displaced persons* (*IDPs*) who risk everything in their search for safety, moving across dangerous borders, only to live in temporary camps for an indefinite period of time. Migration, loss of support networks and family structure, role changes, and innumerable cultural barriers are only some of the challenges that compound adjustment difficulties (Brymer, Steinberg, Sornborger, Layne, & Pynoos, 2008; Slobodin & de Jong, 2015a).

Families play a key role in coping with traumatic stress and resettlement (McIlwaine & O'Sullivan, 2015; Nickerson et al., 2011; Weine, 2011). Interventions following traumatic stress that target different system levels therefore have the potential to improve treatment beyond the individual to his or her interpersonal relationships. The purpose of this chapter is to (a) describe various contexts of traumatic stress and its impact across ecological systems, (b) highlight the consequences of mass trauma and related displacement for global mental health, and (c) review contributions of systemic interventions that address the consequences of relational trauma. The chapter concludes with clinical and methodological challenges in family therapy, along with opportunities and proposed next steps.

We feel distressed over the social injustices and mental health disparities experienced by already vulnerable populations. We therefore use our privileged position as systemic family therapists, collaborating with humanitarians and action-oriented scholars, to integrate our training in systemic prevention and intervention models. In doing so, we call for greater attention in addressing the complex global mental health concerns of populations affected by mass trauma.

Collaborating authors

Elizabeth Wieling immigrated to the United States from South America. She has expertise in treating the effects of traumatic stress at individual and relational levels. Dr. Wieling's research agenda is on developing systemic preventive interventions for communities affected by traumatic stress, including post-conflict, low-income settings and displaced populations. Damir Utržan fled the war in Bosnia-Herzegovina with his parents. They lived in Germany for 10 years before being deported and obtaining asylum in the United States. Dr. Utržan serves as an expert witness/consultant for immigration-related legal proceedings. His research addresses the intersection of conflict-induced trauma, interpersonal relationship dynamics, and human rights law. Alyssa Banford Witting is dedicated to alleviating the symptoms of traumatic stress. Dr. Banford Witting therefore works with women, families, and bereaved parents who experienced natural and human-made disasters. Desiree Seponski's clinical scholarship is on culturally responsive family therapy and intervention, particularly with Southeast Asian families abroad (e.g., Cambodia post-genocide) and in the United States (e.g., refugee family resilience). Dr. Seponski is also co-director of a community outreach program for recently resettled refugees.

Defining Displacement Politically and Socially in Mass Trauma Contexts

Before outlining the systemic impact of traumatic stress, it is vital to discuss relevant terms. We use two composite case studies—family and individual levels—to review working definitions and illustrate some complexities related to traumatic stress and displacement. The depiction of these cases maintains ethical guidelines set by the American Association for Marriage and Family Therapy (AAMFT) while remaining isomorphic to actual clinical encounters. In the family case, we provide a brief synapsis of the San family who came to the United States with refugee status from a camp in the Myanmar–Thailand border. The case is followed by several reflection questions for the reader to keep in mind throughout the elaboration of the chapter. The case of Matías López is one of an unaccompanied minor from Central America seeking asylum in the United States. This case will be intertwined throughout the chapter.

The San family case

Thura and Sanda San[1] *—along with their seven children—are from Burma (also referred to as Myanmar). They were forced to flee from their home village in the 1980s and lived with nearly 200,000 other Karen families in one of nine refugee camps near the Myanmar–Thailand border. In 2017, the Sans were granted asylum in the United States and resettled to a large metropolitan city in the Midwest. The parents witnessed many human rights atrocities in their village and subsequent displacement. Both lost family members and all of their material possessions. Thura, the father, had his lower right leg amputated after stepping on a land mine. They arrived in Thailand with two children and had five more while waiting for resettlement. Because their three oldest children were no longer minors upon their approval for resettlement to the United States, they had to remain behind in Thailand. Thura, Sanda, and their four youngest children arrived in the middle of winter with little English language skills. They were assisted by a local voluntary resettlement agency. While they knew of some friends from the refugee camp in Thailand who were also resettled to the United States, none lived close to them. The mandatory health screening, regulated by the Centers for Disease Control and Prevention (CDC), yielded several health problems. Sanda, the mother, reported pain throughout her body. She also described constant "heaviness in the heart," including "worry and fear," about adjusting to "this new culture." Sanda shared not using the electric stove in their apartment for weeks because of "not knowing how it worked" despite being "desperate to feed the family." She is completely isolated and fearful about parenting in a new country. Sanda's fears are particularly related to being told by others in the refugee camp that she "could lose her children if she disciplined them." Although Thura found work in a waste recycling center, he was fired after three months because of unreliable transportation. He is determined to provide for his family and therefore looking for work located on a bus line so that he does not have to depend on others for rides. Thura reported being "stressed out from the $750 monthly rent" for their apartment and other living expenses, including "a $2,500 airfare loan for coming to the United States." Their children are enrolled in schools and slowly acclimating to the culture. They are learning English, much faster than their parents, and explained a desire to "be good so there is less stress in the family." Chime, the 17-year-old daughter, hopes to become a teacher. But she also feels the need to*

get a job to support the family. Chime noticed that her parents are fighting more than usual and is worried about their relationship. Campo, the 10-year-old middle child, acknowledged trying to hurt himself three times in the past two months by taking a handful of pain relievers. He is afraid of burdening his family and reports not having friends at school. Despite the aforementioned challenges, the Sans are grateful for the opportunity to rebuild their lives in the United States. They are trying to make the best given their situation and cook traditional meals together every night. They also find solace and hope in their faith and attend services regularly. The children are particularly close and take care of each other as their parents work or running errands.

We invite the readers to reflect on a few questions throughout the chapter regarding the San family vignette that may be helpful in further contextualizing systemic work with displaced communities:

- What additional mental health and/or interpersonal relationship assessments may be useful in addition to the CDC-mandated medical evaluation?
- Aside from stress related to resettlement and acculturation, what evidence of exposure to traumatic stress is there?
- What are the implications of the resettlement destination (i.e., city or town) and not having access to a referral system for mental health and/or interpersonal relationship evaluations?
- What are some options for obtaining treatment after the initial mental health and interpersonal relationship screening? Is there local capacity for treatment referrals that are available, culturally appropriate, and effective?
- What is the role of interpreters and cultural insiders or brokers in supporting the resettlement of families?
- What state and federal policies might be needed to support these families? Similarly, what is the role of agencies (e.g., medical and educational) in supporting resettled families?
- What type of role might the local community have in supporting these families?
- How might systemic family therapists collaborate with other professionals, such as social workers and physicians, to support resettled families?

The case of Matías López

Matías López[1] is a 17-year-old unaccompanied single male from El Salvador referred by his immigration attorney for a psychological evaluation. Matías has no prior mental health history, at least not one that he disclosed, but exhibits symptoms of posttraumatic stress disorder (PTSD). Matías was forced to leave El Salvador and come to the United States because of persistent gang violence. The attorney explained that a gang called Mara Salvatrucha or MS-13 may have attacked Matías. A professional Spanish interpreter accompanied Matías to the evaluation. Matías spoke limited English and was reserved but pleasant. "It just was not safe there [because] of the gangs," he responded when asked why he left El Salvador.

Background information *Matías was born in San Salvador, the capital city of El Salvador, as the oldest of three children. His mother was loving and reserved, while his father was emotionally and physically abusive. Matías dropped out of third grade to work*

at a construction site to support his family. "I had no choice, really. My mother's name is Deysi. She worked a little by making and selling necklaces at the local market. But my father, whose name is Juan, never worked. He just stayed at home and drank beer. My brother and sister were too young to work," he explained. Matías left El Salvador after an encounter with MS-13 left him with a broken leg. To pay a coyotaje (i.e., human trafficker), he borrowed $3,000 USD, the equivalent of 14 months' salary in El Salvador (Fair Labor Association [FLA], 2017). "I had no choice, it was either borrow money from Mr. López and come [to the United States] without documents or get killed by the gang," he said.

Initial evaluation *As previously noted, Matías was reserved although pleasant during the initial evaluation. An interpreter was necessary because he spoke limited English and, because he dropped out of third grade, had a relatively limited vocabulary. Matías expressed uncertainty on how to answer questions during the first session. When asked about the violence he experienced from MS-13, he became even more reserved, "I have no idea." The family therapist listened attentively and provided him with space to reflect. A tear formed in Matías' right eye. "The memories […] they just keep replaying in my head," he said.*

The therapist scheduled a second session because Matías had difficulty opening up about his experiences. During that 2-hour session, Matías described being regularly beaten by his father. He also revealed multiple encounters with MS-13, one of whom was his cousin Diego. Incidentally, the long-standing gang violence in El Salvador that Matías described was getting incrementally worse (Centeno, 2017). Inadequate resources and police corruption allowed this threat to grow out of control (UN, 2017a). The assessment found that Matías met the diagnostic criteria for both PTSD and major depressive disorder (MDD) while also suffering from deep relational wounds. He experienced profound sadness over being separated from his family, but also ambivalence over returning because of the impending threats against his life.

Defining and Understanding Forced Displacement/Migration

The overwhelming complexity of this case study is augmented by the absence of universally accepted definitions. Contrary to popular belief, there is no universally accepted definition of *forced displacement/migration* (United Nations Educational, Scientific, and Cultural Organization [UNESCO], 2017). The International Organization for Migration (IOM, 2017) defines it as "[migration from one country to another motivated by] escape [from] persecution, conflict, repression, natural and human-made disasters, ecological segregation, or other situations that endanger [life], freedom, or livelihood." Similarly, the International Association for Refugees (IAFR, 2017) defines forced *displacement/migration* as the "[…] movement of refugees and internally displaced people; those displaced by conflicts, as well as people displaced by natural or environmental disasters, chemical or nuclear disasters, famine, or developmental projects." For Matías, leaving El Salvador and coming to the United States was the only perceived option for survival because neither his father nor the government could protect him from severe gang violence. This context shares similarities with conflict-induced displacement, which we discuss in more detail later.

Irrespective of cause, definitions of forced displacement/migration share core elements of coercion and international movement. A person who has been forced from his or her home, but remains within the borders of their country, is referred to as an IDP as enshrined in the Convention (1951) and Protocol Relating to the Status of Refugees (1967). This legal designation is also recognized by most African countries and has been codified in the Kampala Convention of the African Union (AU, 2017). Because the United States is not party to either, they have no legal nor statutory foundation for mandated action on behalf of IDPs around the world (Brookings Institute, 1999). A "zero-tolerance" policy of undocumented migrants, and some migrants eligible for protective status under current US laws, led to a program for unaccompanied minors from Central America (e.g., El Salvador, Guatemala, Honduras) being phased out (Rosenberg & Torbati, 2017, September 27). For this reason, Matías scrambled to gather enough information to prove his eligibility for asylum before the bureaucratic web of Immigration and Customs Enforcement (ICE) caught him. He was genuinely afraid of being detained at random and without reason, which made it difficult for him to leave the apartment.

Causes of forced displacement/migration

Causes of forced displacement/migration have traditionally centered around natural, or in Matías' case, human-made disasters. The former includes global warming and land degradation, whereas the latter encompass war and organized violence.

Human-made disasters These disasters generally encompass *armed conflict* or *war* and *organized violence*. There are two types of war according to international humanitarian law (International Committee on the Red Cross [ICRC], 2008). The first type is *international armed conflict* that occurs between two opposing countries or independent nation states. "All cases of declared war or of any other armed conflict which may arise between two or more high contracting parties [countries], even if the state of war is not recognized by one of them" (Geneva Convention, 1949) constitute international armed conflict. An example of this conflict is the incident in which unified military forces of Rwanda, Angola, Zimbabwe, and Uganda invaded the Democratic Republic of Congo (DRC) in 1998 (Stewart, 2003). While international armed conflict is synonymous to *war*, the latter has no legal bearing.

The second type is *non-international armed conflict* and occurs between a country and nongovernmental force. An example of this conflict is the 2011 violence that erupted in Syria between the military loyal to Bashar al-Assad and various other armed groups. Again, non-international armed conflict is synonymous to *civil war*, but the latter has no legal bearing. The International Committee of the Red Cross (ICRC, 2008) refrains from classifying conflicts as a *war* or *civil war* because doing so may lead to confusion with other terms outlined in the Geneva Convention (1949).

Regardless of type, conflicts in Afghanistan (United Nations Assistance Mission in Afghanistan [UNAMA], 2017), the DRC (2018), Great Sahel and Lake Chad Basin (UNHCR, 2017c), Kurdistan and Turkey (UNHCR, 2017a), Myanmar (United Nations Population Fund, Asia, and the Pacific [UNFPA], 2017), South Sudan

(Human Rights Watch [HRW], 2017b), Syria (HRW, 2017a), Ukraine (UNHCR, 2017d), and Yemen (UNHCR, 2017b) collectively displaced nearly 9.8 million people and led to the injury or death of over 500,000 people.

The legal standard for asylum in the United States is found in the Immigration and Nationality Act (INA, 1952, 1968). This standard specifies that a person seeking asylum must be "unable or unwilling to return to [his or her] country [of origin] because of persecution or a well-founded fear of persecution on account of [their] race, religion, nationality, membership in a particular social group, or political opinion." Since US Citizenship and Immigration Services (USCIS, 2017) began phasing out the Central American Minors (CAM) Program, Matías' attorney will claim asylum on grounds of belonging to a particular social group. This is a controversial approach but has legal precedent (Meyer & Pachio, 2018). Courts are likely to accept this claim because of previously accepted claims (i.e., precedent) with a positive outcome (i.e., asylum) for the plaintiff (i.e., asylum seeker).

Natural disasters and environmental degradation The International Organization for Migration (2007) defines environmental migrants as "[…] persons or groups of persons who, for compelling reasons of sudden or progressive changes in the environment that adversely affect their lives or living conditions, are obligated to leave their habitual homes, or choose to do so, either temporarily or permanently, and who move either within their country or abroad." They propose that environmental migrants be classified into three categories. The first type is an *environmental emergency migrant*. Due to an environmental disaster (e.g., hurricane), these people flee temporarily, but intend to return. The second type is an *environmental forced migrant*. These people are often forced to leave due to gradually deteriorating conditions in their environment (e.g., deforestation). The third type is an environmentally motivated migrant. These people choose to leave before future problems arise (e.g., declining crop productivity). Since 2011, environmental disasters forced over 19 million people from their homes in Asia and the Pacific (International Displacement Monitoring Center [IDMC], 2015).

Natural disasters include floods, storms, droughts, and extreme temperatures. Despite an increase in natural disasters around the world, there is currently no legal designation or recognition under international law (UNHCR, 2011). Therefore, people forced to leave their home or country due to sudden changes in the environment, *environmental migrants*, are not offered the same legal protection as asylum seekers or asylees (Hartley, 2012).

Environmental degradation is pervasive worldwide and is often the impetus for involuntary displacement. Rising temperatures in North America gradually erode land, which threatens the livelihood of 178 communities (Baumhardt, Stewart, & Sainju, 2015). Climate change looms over the Biloxi-Chitimacha-Choctaw First Nation (Concordia, LLC., & Chicago Bridges, & Iron Company, 2017) in Louisiana and Quinault Indian Nation in Washington (Bureau of Indian Affairs [BIA], n.d.). Rising sea levels in South America are forcing the Guna, a group indigenous to Panama and Colombia, to relocate from islands to the mainland (Displacement Solutions, 2013). Environmental changes may contribute to growing tensions and perhaps war, as populations migrate to already exhausted and impoverished settings (Kemp, Palinkas, & Reyes Mason, 2017).

Systemic Impact of Trauma Exposure

Traumatic stress conceptualizations and definitions

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* (American Psychological Association [APA], 2013) defines a *traumatic event* as including "actual or threatened death or serious injury; threat to one's physical integrity, witnessing an event that involves the above experience, learning about unexpected or violent death, serious harm, or threat of death, or injury experienced by a family member or close associate."

The *International Classification of Diseases (ICD)*, Tenth Edition (World Health Organization [WHO], 2016) does not explicitly define *traumatic event*. Instead, it makes references, whenever appropriate, to delineate diagnostic criteria. Exposure to "[…] a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone," for instance, is required to meet the criteria for PTSD (WHO, 2016). The forthcoming revision (i.e., *ICD-11*) has drawn criticism by removing the number of qualifying symptoms and, in doing so, lowering identification rates by upwards of 60% (Barbano et al., 2018).

Ecological Perspective of Traumatic Stress

Although there is broad universal acceptance of individual responses and cross-cultural applicability consistent with PTSD symptoms, extant sociocultural systemic levels largely influence interpretation and meanings associated with symptoms (Hinton & Lewis-Fernández, 2011). Most notably, we must emphasize the role of culture, context, and intersectional positionalities to better understand population needs across a continuum. Therapists continue to discuss, debate, and refine culturally relevant and variant definitions associated with experience and expression of traumatic stress symptoms (Kessler et al., 2017).

Integrating an ecological framework to our conceptualization of traumatic stress further deepens our understanding of its impact across system levels. This conceptualization provides critical information about how to target and treat traumatic stress across relational levels. Family and systemic therapists are uniquely positioned to apply an ecological framework of mass trauma. We can account for the vast nesting of forces to formulate distinct needs of trauma-affected individuals and families (Hoffman & Kruczek, 2011). An ecological framework is presented here to organize common responses to traumatic stress starting with the individual and their family, the community/country, and world (Harvey, 1996). In the following sections, we extend the previous case example to illustrate the impact of trauma exposure across ecological levels. The traumatic events Matías experienced cut across all ecological levels and affect his organizational self.

Individual

Exposure to one or more traumatic events is often associated with physical and psychological symptoms. Poor general health (e.g., chronic pain or discomfort) and gastrointestinal problems (Pacella, Hruska, & Delahanty, 2013; Taylor et al., 2014) are

the most common complaints. Long-term physical effects of refugee trauma include hypertension, vascular disease, coronary, metabolic syndrome, and diabetes (Crosby, 2013). However, some cultures do not recognize that trauma exposure is associated with physical symptoms (Aragona, Rovetta, Pucci, Spoto, & Villa, 2012). Therefore, a thorough medical evaluation is vital to diagnosing somatization, which is defined as recurrent and pervasive physical symptoms without an organic cause (Waitzkin & Magaña, 1997). We caution that although there is overwhelming scholarly support for the etiology of PTSD and its symptomatology, understanding its meaning course at individual and relational levels necessitates an understanding of the local contexts in which populations are embedded. PTSD diagnosis and treatment should be steeped within broader ecological, cultural, and risk and resilience factors.

It is well documented that PTSD, anxiety, and depression (Kirmayer et al., 2011; Tracy, Norris, & Galea, 2011) are the most common psychological symptoms following trauma exposure. These symptoms are often characterized by hyperarousal, avoidance, intrusions, and cognitive problems, which often lead to sleep disturbances and isolation that interfere with daily functioning. For Matías, the most common PTSD symptoms were agitation or irritability—particularly when being pressed to answer questions, flashbacks, and nightmares. He also had trouble falling and staying asleep in fear of having nightmares.

Relational

Exposure to traumatic events impacts interpersonal relationships (Catani, 2010; McFarlane & Bookless, 2010; Walsh, 2007). People frequently experience considerable emotional discomfort, which not only leads to physical problems but also general dissatisfaction with life. They may feel emotionally numb and anxious, making it uncomfortable to socialize with others. Emotional numbing causes people to isolate themselves, men and women alike, according to Muldoon and Lowe (2012). Significant others become disheartened and angry, emotions that further isolate survivors and compound their PTSD symptoms (Craig, Jajua, & Warfa, 2009). Isolation often yields inflexible boundaries and inverse roles (e.g., parentification); it prevents families from accessing external support and provides inadequate internal support (Henry et al., 2010; Nelson Goff et al., 2006).

A number of studies document the effects of traumatic stress on family and parent–child relationships, particularly related to war and violence. These studies document children's reports of increased parental alcohol use, higher levels of domestic violence and child abuse, and family violence as the most distressing experience of their lives (Catani, Jacob, Schauer, Kohila, & Neuner, 2008; Olema, Catani, Ertl, Saile, & Neuner, 2014; Saile, Neuner, Ertl, & Catani, 2013). Parental PTSD has also been uniquely linked with an increase in self-reported aggressive parenting, indifference and neglect (Stover, Hall, McMahon, & Easton, 2012), lower parenting satisfaction (Samper, Taft, King, & King, 2004), growing challenges with couple adjustment and parenting (Gewirtz, Polusny, DeGarmo, Khaylis, & Erbes, 2010), and lower perceived relationship quality with children (Lauterbach et al., 2007; Ruscio, Weathers, King, & King, 2002). Parental PTSD has also been linked to an increase in children's behavior problems (Caselli & Motta, 1995; Jordan et al., 1992), trauma-related symptoms (Kilic, Kilic, & Aydin, 2011; Polusny et al., 2011), anxiety and stress (Al-Turkait & Ohaeri, 2008; Brand, Schechter, Hammen, Le Brocque, & Brennan, 2011), and depression (Harpaz-Rotem, Rosenheck, & Desai, 2009).

Siegel (2013) argued that neuroscience research supports the saying that "violence begets violence" and that children who witness parental violence are at greater risk for repeating family violence in their own adult intimate relationships. Indeed, evidence substantiates the far-reaching effects of traumatic stress related to war and family violence on parent–child relationships. It also provides strong support for the importance of intervening with parents exposed to traumatic stress. Parents are the most proximal resources to effectively intervene and affect child outcomes in traumatic settings (Gewirtz, Forgatch, & Wieling, 2008; Siegel, 2013; Wieling, 2015; Wieling et al., 2015).

For Matías, forming and maintaining interpersonal relationships (i.e., friendships) was challenging. In El Salvador, he was forced to quit school at an early age and start contributing to the family income by working at a local construction site. He said, "I was probably eight years old when I began working. I would wake up in the morning, maybe have something to eat if there was food, and go to mix cement all day." Matías also did not know whom to trust because members of MS-13 often collaborated with government officials, such as the police. This challenge became even worse after he found out that his cousin was a member of MS-13. "I just…I had no idea who I could trust. Even Diego was a gang member," he said.

Matías struggled opening up and developing trusting relationships. His father was not only emotionally distant but also physically abusive. Juan rarely worked because of heavy alcohol use. He would spend most of the day with friends at a local bar, which was nothing more than a shack with two small tables and a refrigerator, trying to wash away his feelings of guilt. Juan was sad that he could not provide for his family. It is difficult to assess the nature of Juan's addiction and lack of financial stability, but what Matías experienced was daily assaults and being forced to work. This taught Matías at an early age that he could- and should- not rely on other people to meet his needs. It did not matter whether these needs were tangible (i.e., food, shelter) or intangible (i.e., interpersonal relationships); Matías was determined to become self-reliant. The López family illustrates how traumatic stress cuts across system levels.

Community/country

The effects of trauma exposure extend beyond the individual and his or her interpersonal relationships to the community and country at large (Substance Abuse and Mental Health Service Administration [SAMHSA], 2014). Limited theoretical frameworks adequately capture increasing population effects of globalization (Monnier & Hobfoll, 2000). Wright and Bartone (2001) propose a multilevel *community of meaning* framework to explain the ripple effect of traumatic stress. At the inner level is the person or group that directly experiences or witnesses a traumatic event. The next level encompasses community leaders and facilitators of collective grieving. They encourage community members to unify in solidarity, because traumatic events can strain relationships. Another level consists of professionals, such as first responders, and community members directly involved in the recovery process. Professionals provide survivors with comfort, advice, and valuable information. At the outermost level is the infrastructure. This includes local and national government officials who coordinate recovery efforts and provide resources. In El Salvador, Matías did not seek help from government officials because they were often engaged in torture and extrajudicial killings. In the United States, Matías relies on

professionals with various levels of competence and waits for an overextended executive judicial system to evaluate his case.

World

Although not immediately apparent, the effects of mass trauma have a global impact. Sociopolitical events (e.g., conflict) influence people and create shared experiences between members of that generation (Mannheim, 1997). Communication using technology forms a global generation (Edmunds & Turner, 2005). People around the world, now more than during any other time in history, share their experiences almost instantaneously over social media without concern for boundaries. Indeed, social media was critical to promoting the Arab Spring (Howard et al., 2011). Protestors used Facebook and other social networking platforms (e.g., Twitter) to organize demonstrations for- and against- the al-Assad regime. They also used media to disseminate information and raise awareness. However, countries that regulate access to the Internet (e.g., China) are obstacles to a global consciousness.

Physical travel is another critical component of maintaining virtual relationships (Urry, 2003). Absence of physical travel, which is frequently associated with virtual relationships, decreases overall contact. Taken together, news of traumatic events transmitted around the world enters generational consciousness. For Matías, hope of survival propelled him across several international borders. Technology assists him in keeping minimal connection with his family. He depends on international conventions and national policies in the United States to determine what is possible for his future.

Mental Health Concerns Related to Traumatic Stress and Displacement

Displaced populations experience disproportional levels of mental health and relational distress. The adverse consequences of trauma exposure are well documented (de Jong et al., 2001; Hebebrand et al., 2016; Nickerson et al., 2011). In a meta-analysis with over 80,000 refugees, Steel et al. (2009) reported between 13 and 25% PTSD prevalence rate. A symptom severity study of PTSD and depression conducted with 688 refugees in the Netherlands (Knipscheer, Sleijpen, Mooren, ter Heide, & van der Aa, 2015) supported these estimates. Torture and cumulative exposure to traumatic events increase PTSD symptoms, with prevalence upwards of 86% (Hollifield et al., 2002). Studies document the enduring effects of pre-migration traumatic stress even years after resettlement (Marshall, Schell, Elliott, Berthold, & Chun, 2005). Additionally, PTSD is higher for refugees who spent time in refugee camps affected by war than for other resettled communities (LaCroix & Sabbath, 2011).

Displacement predisposes people to additional traumatic events while also disrupting their familial and social network (Nickerson et al., 2011). They may experience a sense of helplessness, damaged trust, shame, and/or humiliation following traumatic experiences (e.g., rape, physical violence, witnessing death) while suffering separation (Sideris, 2003). Forcibly displaced migrants encounter complex health needs as a result of stressful resettlement experiences, conditions faced in their home and

destination countries, multifaceted political dimensions, and racism and acculturation stressors (Hanson-Bradley & Wieling, 2016). People who left their homes are also under duress, and if they have not been granted asylum before entering another country, their risk increased mental health problems (Hansson, Tuck, Lurie, & McKenzie, 2012).

Despite this intensity of need, asylum seekers and refugees may have to wait months and sometimes years to receive necessary psychiatric help (Altunoz, Nunez, & Calliess, 2016). They may face additional barriers to seeking mental health services, including lack of culturally competent professionals, service accessibility, lack of culturally validated screening and assessment tools, lack of professionals trained to deliver trauma-focused treatments, and lack of trust and difficulties with continuity of care, among others (Colucci, Minas, Guerra, & Paxton, 2015; Shannon, Simmelink et al., 2015).

For Matías, accessing mental health services was a primary barrier. He did not have health insurance and was ineligible for government assistance, whether insurance or otherwise. He could therefore not visit a local provider. A secondary barrier was social stigma; more specifically, Matías feared being discovered as an unaccompanied minor without documentation and risking deportation to El Salvador. This fear worsened exponentially after the Trump administration introduced a "zero-tolerance" policy of undocumented migrants and began rolling back the CAM Program. He did not know if he would be deported or granted relief. Matías thought that the former would certainly be the end of his life, while the latter, however unlikely it may seem, would give him an opportunity to repay his debt and rebuild his life.

Uncertainty considerably exacerbated his PTSD symptoms during a sensitive developmental period.

Need for Systemic Interventions

The needs of displaced and traumatized families correspond to clinical challenges facing the mental health field broadly and family therapists specifically. A special panel on global mental health assembled by the National Institutes of Health (Collins, Patel, & Joestl, 2011) found that identifications of early interventions are priority issues following natural and human-made disasters. Clinical questions addressing these challenges are poignant and emphasize the need for expanded focus and innovative thinking to respond effectively. These salient questions include the following:

- How can we help trauma-affected and displaced populations reorganize their individual, family, and social structures as they are pressed through internal and external changes that disrupt known patterns within their ecosystem?
- How can we be a part of a coordinated global response to the unprecedented scale of this humanitarian crisis?
- How can we help people process, integrate, and deal with the host of violations, systematic violence, persecution, interpersonal traumas, and stripping of human rights they may face in this inexorable deluge of stress?

In asking these questions and considering how the field might adapt and grow in response, it is vital to honor not only the great resilience displayed by displaced

populations but also the direct and long-term adversities they experience. It is also vital to continue pursuing a deeper understanding of the intersection of traumatic stress and forced displacement because they collectively inform global health issues.

Systemic Interventions for Trauma-Affected and Displaced Populations

Interventions for displaced families deserve special attention due to the levels and complexities of traumas they face. There is an absence of mental health interventions, that is, relational interventions, because most treatment is individual. Utržan and Northwood (2016) applied ambiguous loss theory (Boss, 2006, 2018) to understanding the systemic effects of traumatic stress in torture survivors. They suggest framing interventions, regardless of type, as a profound loss that suspends people in a perpetual state of uncertainty. This enables clinicians to address the various needs families present with upon their arrival to the United States.

With exception of narrative exposure therapy (NET) (Schauer, Neuner, & Elbert, 2011) and cognitive behavioral therapy (CBT) (Beck, 1970), most interventions have not been evaluated or validated for clinical application with refugee families (Nosé et al., 2017; Slobodin & de Jong, 2015a). Even though family therapy seems to be the recommended treatment for displaced families, there is very little research on systemic interventions with families displaced from their homes and countries (Slobodin & de Jong, 2015b). Frequently cited reasons that limit intervention with families are (a) inadequate mental health systems to accommodate war crisis and displacement, (b) limited published reports of involvement by family therapists who assist displaced families, and (c) insufficient systemic culturally sensitive tested models of intervention (Patterson, Abu-Hassan, Vakili, & King, 2017; Patterson, Edwards, & Vakili, 2018; Slobodin & de Jong, 2015a, 2015b; Wieling, Mehus, Yumbul, et al., 2015). The following interventions have been implemented in post-conflict, low-income settings or with refugee and asylee families who have relocated to high-income countries in the last decade. This list offers recent exemplars of systemic models and frameworks across various relational contexts.

It should also be noted that any intervention(s) introduced to prevent or ameliorate the consequences of traumatic stressors on a population ought to be done with depth of understanding of the local context and ideally in collaboration with key stakeholders. Two growing areas of scholarship can be used to guide the integration of such interventions with trauma-affected communities: cultural adaptation and dissemination and implementation (Sousa & Rojjanasrirat, 2010). Researchers offer multilevel ecological frameworks for ethical community engagement with vulnerable populations. We stress the need to pilot and field test systemic interventions for supporting families and communities in the aftermath of mass traumas and displacement.

Enhancing Family Connection (EFC)

Enhancing Family Connection (EFC) is a trauma-focused parenting intervention adapted and tested in a post-conflict setting and later with a resettled refugee community in the United States (Ballard, Wieling, & Forgatch, 2017; Wieling,

Mehus, Möllerherm, et al., 2015; Wieling, Mehus, Yumbul, et al., 2015). The first feasibility study was conducted in Northern Uganda, the setting of a brutal civil war that lasted nearly two decades. EFC was developed as a nine-session preliteracy intervention, visually manualized to fit the cultural and contextual characteristics of families in the region. EFC parenting components were adapted from the Parent Management Training—Oregon (PMTO) Model with over 40 years of evidence (Forgatch & DeGarmo, 1999; Forgatch & Domench Rodriguez, 2015). Additional EFC content areas included psychoeducation on individual and relational effects of traumatic stress, intergenerational transmission of violence, substance abuse, and other risk-taking behaviors. Early stages of cultural adaptation began with several parent focus groups, family interviews, and testing observational parent–child measures.

The team successfully implemented EFC with two groups of mothers. Changes in mothers clustered around (a) the use of positive reinforcement, encouragement, and praise, (b) changes in discipline behavior, and (c) changes in parental involvement. Children reported less conflict in the home and more positive involvement. Mothers and children showed evidence of changes that demonstrate the potential efficacy of EFC in changing parenting behaviors in this community.

A similar cultural adaption process and feasibility test of EFC was conducted with a Karen refugee community resettled from Burma/Myanmar to the United States. The study showed early promise of acceptability, usability, and limited effectiveness (Ballard et al., 2017). Karen caregivers reported changes in their teaching, directions, emotional regulation, discipline, and child compliance. Children reported changes in the same areas, in positive parent involvement and a decrease in mental health symptoms.

Couple Adaptation to Traumatic Stress (CATS)

The Couple Adaptation to Traumatic Stress (CATS) model works with couples that have experienced traumatic stress (Nelson Goff & Smith, 2007). This model addresses interpersonal impacts of trauma, such as changes in family roles, boundaries, and intimacy, and addresses triggers and coping mechanisms (Oseland, Gallus Schwerdtfeger, & Nelson Goff, 2016). To create a systemic intervention for traumatized couples, Oseland et al. (2016) combined the CATS model with Herman's (2005) model of trauma and recovery. Their modified CATS model regards couple communication as the core competency for successful therapeutic outcomes in partners who have faced traumatic stress.

Communication facilitates three primary processes that are effective for treatment: (a) safety and stability, (b) conjoint processing, and (c) connection (Oseland et al., 2016). Therapists assist couples in increasing their sense of safety and stability so that they can control maladaptive behaviors such as suicidal behaviors, substance abuse, and intense relational conflict. Therapists model safety during the therapeutic relationship and equip couples with crisis management techniques (Oseland et al., 2016). This model ends with couples establishing a deeper connection with each other, repairing attachment bonds with each other, and reestablishing important bonds with family members and community friendships (Oseland et al., 2016).

Torture-Surviving Couple Group (TSCG)

The Torture-Surviving Couple Group (TSCG) was composed of family therapists and psychologists from the Center for Victims of Torture (Morgan, Wieling, Hubbard, & Kraus, 2017). The team conducted the first known feasibility study of a group for

couples who survived torture in a post-conflict, low-income setting. They developed the model in the DRC in a community that experienced widespread torture during wars from 1998 to 2004. This model is a short-term intervention designed to address relational difficulties resulting from exposure to traumatic stressors.

The ecological, neurobiological, attachment, and narrative therapy frameworks were used to guide model development. An existing multi-couple group for addressing violence (Stith, Rosen, McCollum, & Thomsen, 2007) and a stage model for healing trauma (Herman, 1992) further guided the structural development of TSCG. Thirteen couples met weekly in a ten-session program. Sessions emphasized themes in four phases: (a) preparation, (b) safety and stabilization, (c) processing the relationship effects of trauma and grief, and (d) reintegration and rebuilding couple and family life. After participating in the groups, couples reported remarkable progress in their relationships.

Families OverComing Under Stress (FOCUS)

Families OverComing Under Stress (FOCUS) (Saltzman, 2016) is a brief intervention for families exposed to traumatic events. By improving communication, families can make meaning of the trauma and practice skills that support resiliency. The model was originally developed for military families but has been used with civilians, including displaced persons who experienced traumatic events. Longitudinal studies show the model effectively decreases PTSD, anxiety, depression, and behavioral and emotional challenges while increasing family well-being and positive child behaviors (Saltzman, 2016). This model is based on five core elements (i.e., mental health assessments, psychoeducation, individual narratives, communication skills, family resources). As a brief intervention, therapy lasts between six and eight sessions.

Prevention and Access Interventions for Families (PAIF)

The Prevention and Access Interventions for Families (PAIF) provides community support for families who have lost everything after war (Pejic, Alvarado, Hess, & Groark, 2017). This family-focused and community-based intervention helps refugee families adapt to their country of relocation. PAIF considers the impact of trauma, involuntary migration, and acculturation on the family mental health. The model is based on the belief that family support will enhance family acculturation processes in the relocation country, because families are the context for social and psychological recovery from traumatic experiences (Pejic et al., 2017). For sustainable interventions, PAIF emphasizes treating families as the central focus of the intervention, collaborating with local community resources who are able to provide basic and other needs for families and working from a strength-based perspective. Through situating family processes within community adjustment, PAIF addresses mental well-being with outcomes of helping families achieve optimal community integration.

Transnational Intersectionality Framework (TIF)

Transnational Intersectionality Framework (TIF) focuses on social structures of oppression and power that tend to work against refugee families and heighten the stress and anxiety associated with refugee relocation (Gangamma & Shipman, 2017).

Transnationalism refers to the idea that many refugee families are often scattered around the world and have to maintain family relationships across several countries. Strict resettlement policies that prevent family members from relocating at the same time or to the same country further complicate issues. Geographic distance isolates family members from each other and creates anxiety, depression, and diaspora.

Intersectionality is the critical consideration of how people and institutions with power and privilege oppress those with less power based on demographic factors (e.g., age, gender, religion) and social locations (e.g., low income, refugee); for instance, displaced populations have virtually no say in how host countries treat them and often face discrimination based on their religion (Gangamma & Shipman, 2017). Gangamma and Shipman (2017) propose extending this framework to traditional family therapy models for use with migrants. The authors propose that therapists should have a critical comprehension of the transnational contexts of refugee families and proactively address social injustices against refugee families. Therapists should also examine personal biases and power differences that exist in the clinical relationship while confronting various prejudices (e.g., social, political, cultural).

Recommendations for Working Systemically with Displaced Families

The following recommendations can help family therapists enhance treatment plans with trauma-affected refugees. However, implementation will depend on the unique needs of each family and community setting.

Migrant families as stakeholders

Some families come from countries where family therapy and counseling are not readily available. There is a great likelihood that the first clinicians that refugees encounter in their country of resettlement are not representative of their own cultural background and have a different demographic status. For both parties to learn from each other, they must establish strong rapport while creating long-term goals. Families can explain their cultural conceptualization of mental health and share culturally specific community strengths (Pejic et al., 2017). Engaging refugee families as investors in therapy is the foundation for competent cross-cultural interventions.

Integrating cross-cultural perspectives

Working from a cross-cultural perspective may require considerable energy but promises long-term effects for the psychological well-being of displaced families. Showing cross-cultural responsiveness shows respect for refugee families' cultures, norms, and traditions and decreases the power associated with a therapist's Eurocentric knowledge. A cross-cultural stance means inquiring about culturally specific symptoms, diagnosis, and intervention and integrating traditional healing practices into treatment plans. Therapists should also seek to remain culturally and contextually relevant. In an intervention with Kosovars, therapists did not refer to themselves as "fixing the

family," thus avoiding the interpretation that something may be wrong with members and increasing the stigma related to mental health (Shahini, Ahmeti, & Charlés, 2016). During therapy time, clients should not use their therapy time to educate the therapist as cultural brokers. Therapists should seek other ways of learning about clients' culture outside therapy times.

Employing a strength-based focus

While their natural capacities may be overwhelmed, refugee families have shown great strength by persevering through their migration processes (Patterson et al., 2017; Pejic et al., 2017). Many families are inundated with trauma symptoms, comorbid disorders, and various stressors. They need additional protective factors to intersect with their difficulties, such as supportive networks. Taking a strength-based approach does not mean undermining the difficulties that displaced families face; it means acknowledging that they can have hope and they have strengths to assist them in their journey of recovery.

Enhancing community support

Community networks connect refugee families to resources and local assets; neighbors with knowledge of home and resettlement countries act as cultural brokers between service providers and displaced families (Pejic et al., 2017). Indeed, members of the same national group often support each other in processing personal and communal historical events (Miller, 2016). Utržan, Wieling, and Piehler (2018) conducted a needs and readiness assessment of the US Refugee Resettlement Program. Although they primarily focused on Syrian asylum seekers and refugees, several interesting findings emerged that can be generalized to other groups. Trump administration policies indirectly limited existing resettlement practices by reducing or altogether eliminating funding streams. This set the United States on track to admit the fewest number of refugees since creation of its resettlement program (Stolle, 2018). Agencies became unable to provide families with access to even the most basic needs (e.g., adequate housing, employment). To make matters worse, community members expressed anti-refugee sentiment informed by a general misunderstanding of processes. Their study not only illustrates the interconnectedness of different system levels but also confirms that shifting the sociopolitical climate requires changing community attitudes.

Interdisciplinary interventions

For refugee families to benefit from mental health interventions, basic needs (e.g., housing, food, language acquisition, employment) should be met first. Therapists are advised to collaborate with other service providers, such as social services (Pejic et al., 2017; Shahini et al., 2016), so families receive holistic care. Interdisciplinary collaboration is important because some cultures do not discuss family issues with a stranger; families may think mental health counseling indicates insanity (Miller, 2016). But they can seek help from spiritual and religious leaders, doctors, and healers (Miller, 2016). If familiar or aware of the professionals with whom refugee families interact, clinicians can develop collaborative relationships that promote healing and recovery.

Conclusion

We reiterate our initial call for action to increase awareness and activism in addressing global mental health, in general, and the needs of displaced populations affected by traumatic stress, in particular. The social action needed to cut across ecological levels is complex. In the aftermath of mass traumas and displacement, clinicians must be politically aware and sensitive (Charlés, 2014; Shannon et al., 2014). They should leverage strength-based approaches that draw on resilience and family culture (Hughes, 2014). Trauma-focused and strength-based approaches may overcome stigma and fear that dissuade many resettled communities from seeking mental health assistance. Systemic clinicians working with trauma-affected populations might adapt individual evidence-based treatments for populations affected by multiple traumatic stressors and PTSD (e.g., NET, CBT); they can use multilevel components (i.e., individual, couple, parent, family) in their long-term treatment goals. Prevention and clinical researchers must continue the critical journey of developing, adapting, and testing systemic family-based interventions after mass trauma and displacement. Family practitioners should record their case studies, conduct systematic meta-analyses, and disseminate their important clinical work with displaced populations. Family therapy training programs should forge strong and trusting relationships with displaced populations in their communities and collaborate with low- and middle-income countries.

Trauma-focused family therapists can promote specialized training and research to establish culturally responsive, evidence-based family models, which address broader translational science frameworks that include transportability and sustainability. Policy implications for addressing mental and relational health needs of trauma-affected displaced populations are vast and range from local to international levels. Currently, Matías can no longer apply for Deferred Action for Childhood Arrivals (DACA) to postpone deportation while he applies for asylum. His attorney retained a clinician to perform a psychological assessment. The attorney will argue that Matías, as an adolescent, is entitled to asylum in the United States because he belongs to a particular social group. A decision may take from a few months to several years; until then Matías remains separated from his family and suspended in a perpetual state of uncertainty. As for the San family, they were fortunate to resettle to a location that had a concurrent collaborative study at the time they had their medical exams, and the family was offered treatment for traumatic stress, parenting classes, and family support. They were also referred to a social worker who aided them in communicating with the school system about their children and connected them to other volunteer resettlement agencies. The San family experience was an exception as the majority of resettled families do not receive the initial support needed for more rapid and successful resettlement.

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Note

1 The San family and Matías López names are pseudonyms used to secure the confidentiality of those described in the vignettes. The cases are composites of actual families. Several strategies such as disguising specific content, including extraneous material, and placing limits to specific descriptions have been incorporated throughout the cases for additional protection.

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